Nicotine Usage/Non-Usage Statement

RETIREE

The surcharge on the medical plan imposed for the use of Nicotine Products is $120 per month per family. To avoid the surcharge, covered participant must not use nicotine products or those who do must enroll in a cessation program offered by Cigna.

<u>If your nicotine usage status has changed, you must submit this affidavit by the annual open enrollment deadline or qualifying life event.</u>

- Please complete this form and return it with your annual enrollment forms or qualifying life event.

I, _____, hereby certify that: Please check the applicable box:
(Retiree/Surviving Spouse's Full Name)

☐ I and all of my insured dependents **do not use** nicotine products. I also certify that I have not used any nicotine products in the last 60 (sixty) days including, but not limited to, pipes, cigarettes, cigars, chewing tobacco, snuff, or any other type of smoking or smokeless tobacco (i.e., one usage of any tobacco product in the last 60 days is tobacco use). By completing this Verification and certifying my non-tobacco user status, I know that I will not be subject to the $120 per month "Nicotine Surcharge" on my medical plan contributions.

☐ I or a covered dependent **has used** nicotine products in the 60 (sixty) days including, but not limited to, pipes, cigarettes, cigars, chewing tobacco, snuff, or any other type of smoking or smokeless tobacco (i.e., one usage of any tobacco product in the last six months is tobacco use). I understand that I will be subject to the $120 "Nicotine surcharge" on medical plan contributions.

To avoid the Nicotine Surcharge I understand that any nicotine users covered under my medical plan must complete an approved Nicotine Cessation Program or obtain the appropriate medical certification. I understand the nature and content of this document, I am aware that if I or a covered dependent uses, or begins the use of nicotine products, from the date this statement is signed and I do not advise the City of Memphis of this use within two weeks after it occurs, I will be considered to have falsified information and I may be subject to disciplinary action, up to and including termination, subject to repaying all claims paid under the medical plan and/or I will be subject to the Nicotine Surcharge.

Retiree/ Spouse Name: _____ Employee ID: _____ Last 4 of Employee SSN: _____
(Please print full name)

Signature: _____ Date: _____

Names of covered dependent(s) that use Nicotine Products:

NAME	RELATIONSHIP

Health, Wellness & Benefits Office Use Only:

Retiree Enrollment Date:	Termination Date:	Employment Status:	Received By Date:	Entered By/Date: